

NHA Certified Billing and Coding Specialist (CBCS) Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 - 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. Which describes the organization of an aging report?**
 - A. By date**
 - B. By patient name**
 - C. By account number**
 - D. By service type**

- 2. Which of the following is a key component of an evaluation and management service?**
 - A. History**
 - B. Examination**
 - C. Medical decision making**
 - D. Counseling**

- 3. Which phrase best describes the need for a supplementary item with a paper claim?**
 - A. The claim requires an attachment**
 - B. The claim lacks any attachments**
 - C. The claim is fully complete electronically**
 - D. The claim is rejected automatically**

- 4. Which law prohibits a provider from referring Medicare patients to a clinical laboratory service in which the provider has a financial interest?**
 - A. Stark Law**
 - B. Anti-Kickback Statute**
 - C. False Claims Act**
 - D. Health Care Fraud Statute**

- 5. In CPT coding, which symbol indicates a product pending FDA approval?**
 - A. Lightning bolt**
 - B. Star**
 - C. Circle with slash**
 - D. Hash**

- 6. If you witness unethical conduct by a colleague, what action is appropriate?**
- A. Report the incident to a supervisor**
 - B. Confront the colleague publicly**
 - C. Ignore the situation**
 - D. Document privately and do nothing**
- 7. Z codes are used to identify**
- A. Immunizations**
 - B. Diagnoses**
 - C. Procedures**
 - D. Medications**
- 8. In which block on the CMS-1500 claim form should the referring provider's national provider identifier (NPI) be entered?**
- A. Block 17b**
 - B. Block 24A**
 - C. Block 32**
 - D. Block 21**
- 9. In billing terms, what term describes the amount the policyholder owes the provider after all other payments are applied?**
- A. Cost sharing**
 - B. Surcharge**
 - C. Fee Schedule**
 - D. Discount**
- 10. Which report is used to organize accounts receivable from the date of service?**
- A. Aging report**
 - B. Trial balance**
 - C. Cash receipts**
 - D. General ledger**

Answers

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1. A
2. A
3. A
4. A
5. A
6. A
7. A
8. A
9. A
10. A

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Explanations

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1. Which describes the organization of an aging report?

- A. By date**
- B. By patient name**
- C. By account number**
- D. By service type**

An aging report is focused on how long a balance has remained unpaid. Organizing it by date, typically the date of service or the date the invoice was issued, puts the oldest outstanding charges at the top and shows how long each item has been overdue. This time-based arrangement makes it easy to prioritize collections, identify problem accounts early, and monitor overall aging trends. Sorting by patient name, account number, or service type wouldn't highlight the urgency of unpaid balances or help with timely follow-up in the same way, since those factors don't reflect how long the debt has been outstanding.

2. Which of the following is a key component of an evaluation and management service?

- A. History**
- B. Examination**
- C. Medical decision making**
- D. Counseling**

In evaluation and management documentation, history is one of the primary elements used to determine the level of service. It captures the patient's subjective information—the chief complaint, history of present illness, review of systems, and past, family, and social history—which frames the encounter, helps the clinician decide what to examine, and guides medical decision making. While the physical examination and medical decision making are also essential components for determining the level of service, counseling or coordination of care is not counted as a standalone core element in most coding guidelines. It can be documented when significant time is spent or bundled into the other components. So, history is the best answer because it is a foundational element used to establish the context and scope of the evaluation.

3. Which phrase best describes the need for a supplementary item with a paper claim?

- A. The claim requires an attachment**
- B. The claim lacks any attachments**
- C. The claim is fully complete electronically**
- D. The claim is rejected automatically**

Some paper claims require extra documentation to support what was billed. The phrase that best fits this situation is that the claim needs an attachment. Attachments provide the additional information—such as medical records, test results, or a narrative justification—that the form itself can't fully convey. Without these supplementary documents, the submission is considered incomplete and may be delayed or returned for missing information. The other options describe conditions that aren't about needing extra documents: lacking attachments implies no extras are needed, fully complete electronically refers to electronic submissions rather than paper ones, and a claim being rejected automatically is an outcome, not a description of the need for extra documentation.

4. Which law prohibits a provider from referring Medicare patients to a clinical laboratory service in which the provider has a financial interest?

- A. Stark Law**
- B. Anti-Kickback Statute**
- C. False Claims Act**
- D. Health Care Fraud Statute**

Stark Law prohibits physician self-referral of designated health services, such as clinical laboratory services, to an entity with which the physician has a financial relationship. If a provider owns or has a financial arrangement with a lab, referring Medicare patients to that lab would typically violate Stark Law unless an applicable exception or safe harbor applies. This is a civil, strict-liability rule that can lead to penalties like denial of payment, refunds, civil monetary penalties, and possible exclusion from programs. While the Anti-Kickback Statute also targets improper referrals, it focuses on kickbacks and payments to induce referrals and generally requires knowledge or intent, making Stark Law the more direct prohibition in this self-referral scenario. False Claims Act and broader health care fraud provisions address submitting or causing false claims, not the specific self-referral restriction at issue here.

5. In CPT coding, which symbol indicates a product pending FDA approval?

- A. Lightning bolt**
- B. Star**
- C. Circle with slash**
- D. Hash**

The symbol that signals a product pending FDA approval is the lightning bolt. This mark flags items that are new or newly introduced but not yet cleared by the FDA, so coding and billing must account for the device's regulatory status. When you see this symbol, you should verify the current FDA standing and be aware that payers may have additional documentation or evidence requirements, or may delay or deny reimbursement for unapproved devices. The other symbols convey different alerts about codes (such as new or revised codes or reporting requirements) and do not indicate FDA-pending status.

6. If you witness unethical conduct by a colleague, what action is appropriate?

- A. Report the incident to a supervisor**
- B. Confront the colleague publicly**
- C. Ignore the situation**
- D. Document privately and do nothing**

When you witness unethical conduct, your responsibility is to escalate the concern through the proper channels so it can be reviewed and addressed. Reporting the incident to a supervisor or appropriate authority within the organization ensures there is a formal investigation, protects patient safety, and upholds professional standards. It also provides a clear, documented path for accountability and any necessary corrective action, while allowing protections under workplace policies. Confronting the colleague publicly undermines professionalism, can escalate tension, and may jeopardize patient safety without giving the issue a fair, documented review. Ignoring the situation or merely documenting privately and doing nothing leaves the behavior unchecked and potential harm unaddressed, which is not acceptable in a healthcare setting.

7. Z codes are used to identify

- A. Immunizations**
- B. Diagnoses**
- C. Procedures**
- D. Medications**

Z codes identify factors that influence health status and the reasons for patient encounters, such as an encounter for immunization. They provide context for the visit and document services delivered, like vaccination status. For immunizations, the specific Z code used is Z23, which makes immunizations the best fit among the choices. Diagnoses are coded with ICD-10-CM disease codes, procedures with ICD-10-PCS or CPT, and medications with separate pharmacologic codes, so those options don't describe Z codes.

8. In which block on the CMS-1500 claim form should the referring provider's national provider identifier (NPI) be entered?

- A. Block 17b**
- B. Block 24A**
- C. Block 32**
- D. Block 21**

The key idea is placing the referring provider's unique identifier in the part of the CMS-1500 that collects information about the physician who referred the patient. The referring provider's NPI is a 10-digit number that uniquely identifies the physician who initiated the referral, and it must appear in the section of the form reserved for the referring physician's information. This placement ensures the payer can correctly link the referral to the claim, aiding proper adjudication and care coordination. Other sections of the form are used for the rendering provider, service details, or facility information, so putting the referring NPI in those areas would obscure who originated the referral and could delay processing.

9. In billing terms, what term describes the amount the policyholder owes the provider after all other payments are applied?

- A. Cost sharing**
- B. Surcharge**
- C. Fee Schedule**
- D. Discount**

Cost sharing is the portion of healthcare costs that the insured must pay after the insurer has paid its share. It includes the deductible, copayment, and coinsurance that the policyholder is responsible for under the plan. After the insurer's payment and any plan adjustments are applied to the bill, the remaining amount the patient owes falls under cost sharing. This distinguishes it from a surcharge (an extra fee), a fee schedule (the listed prices for services), or a discount (a reduction in price).

10. Which report is used to organize accounts receivable from the date of service?

- A. Aging report**
- B. Trial balance**
- C. Cash receipts**
- D. General ledger**

An aging report organizes accounts receivable by how long they've been outstanding from the date of service. It places each unpaid balance into time buckets—such as 0-30 days, 31-60 days, 61-90 days, etc.—so you can see which amounts are current and which are delinquent. This helps with cash flow planning and prioritizing collections, since you can target the oldest, most overdue balances first and estimate the potential bad debt. The other reports have different purposes: a trial balance lists all accounts with their balances to verify the books balance; a cash receipts report shows payments that have been received; the general ledger is the comprehensive record of all financial transactions. But only the aging report specifically groups receivables by how long they've been outstanding since the service date.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://nhacbcs.examzify.com>

We wish you the very best on your exam journey. You've got this!

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